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Congress of the United States

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December 1, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Mr. Slavitt,

We write today following up on concerning findings from an October 23rd Subcommittee on Health hearing that reviewed the inaccuracy of Medicaid and exchange eligibility determinations. We are very concerned that the lack of meaningful eligibility controls in Medicaid and the exchanges established under the Affordable Care Act (ACA) puts American tax dollars at risk.

According to the Congressional Budget Office, the estimated cost of subsidies and related spending under the ACA between fiscal years 2016 and 2025 is nearly $850 billion.[1] Federal expenditures for the Medicaid expansion are estimated by the CMS Office of the Actuary to be $430 billion from 2014 through 2023.[2] With the enormous costs of these programs, it is vital to ensure that American tax dollars are being spent appropriately.

On October 23rd, members heard testimony from witnesses from the Government Accountability Office (GAO) regarding the agency's assessment of Medicaid and exchange eligibility controls and coordination. This testimony covered two new GAO reports–one on Federal and State policies and procedures to minimize duplicative coverage by Medicaid and qualified health plans offered by exchanges, and the other on Federal efforts to ensure the accuracy of Medicaid eligibility determinations and the Federal matching rate for State Medicaid expenditures.[3] GAO also testified on findings from undercover testing of Federal and State exchanges' application, enrollment, and eligibility verification controls, for both qualified health plans and Medicaid, including opportunities for potential enrollment fraud, during ACA's second open enrollment period.[4]

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[1] https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf
[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2014.pdf
[3] http://www.gao.gov/assets/680/673026.pdf and http://www.gao.gov/assets/680/673159.pdf
[4] http://www.gao.gov/assets/680/673286.pdf

We are deeply concerned about some of GAO's key findings:

- GAO found significant weaknesses in the Centers for Medicare and Medicaid Services (CMS) oversight of Medicaid, and operation and oversight of the exchanges. For example, GAO identified weaknesses in CMS's controls for preventing, detecting, and resolving duplicate coverage, as well as a lack of strategy to monitor these efforts.

- GAO also found that CMS does not have a process in place to ensure that states are claiming the appropriate federal matching rate for Medicaid beneficiary expenditures. Thus, CMS has no way to know if the expenditures for which states are claiming 100% federal funding are accurate or should only be funded at the state's regular matching rates, which average about 58 percent.[5]

- GAO testified that their undercover testing found systematic weaknesses in the federal exchange that appear to indicate that CMS is placing coverage over program integrity. Despite CMS having sufficient information from GAO's July 2014 and July 2015 testimonies on vulnerabilities found during the ACA's first open enrollment period for plan year 2014, *GAO did not find any improvements in the federal exchange's control environment for plan year 2015.*[6]

- GAO also found vulnerabilities in the State marketplaces similar to the federal exchanges. As a result of these vulnerabilities, the Federal and selected State exchanges approved subsidized coverage, either private plans or Medicaid, for 17 of 18 fictitious applicants, including applicants that provided impossible Social Security or immigration document numbers.

Given the recent GAO reports, and the enormous potential for waste of taxpayer dollars in the Medicaid program and ACA exchanges, we request answers to the following questions:

1) According to GAO, State Medicaid Directors raised concerns that Medicaid eligibility determinations made by the federal exchange were incorrect. Despite these concerns, GAO noted that at the time of their work CMS was not assessing the accuracy of federal eligibility determinations, but that CMS officials indicated that the agency was planning to begin looking at such determinations in August. What is CMS doing to examine the accuracy of federal eligibility determinations and what has CMS found?

2) As part of CMS's quarterly standard review of Medicaid expenditures submitted through the CMS-64, CMS staff select a sample of different types of enrollees, including at least 25 ACA-expansion eligible enrollees, 10 state-expansion eligible enrollees (where applicable), and 5 traditionally eligible enrollees, to examine their expenditures to ensure that they were reported as expenditures for the correct eligibility type. How did CMS

[5] http://docs.house.gov/meetings/IF/IF14/20151023/104090/HHRG-114-IF14-Wstate-YocomC-20151023.pdf
[6] http://www.gao.gov/assets/670/664946.pdf and http://www.gao.gov/assets/680/671441.pdf.

determine the sample size? Is the sample size statistically significant and can the results be generalized?

3) According to GAO, the quarterly expenditure reviews only assesses whether expenditures for an enrollee that a State claims to be newly eligible is submitted under the newly eligible expenditure category and not whether the enrollee is truly newly eligible. Given the 100 percent federal funding for the newly eligible, States obviously have a financial incent to increase the proportion of applicants and expenditures for that population. As such, what is CMS doing to ensure that expenditures claimed under the higher federal matching rate are indeed for individuals that are newly eligible?

4) Last year CMS did not check for Medicaid coverage for the 1.96 million individuals who the agency auto-enrolled in qualified health plan for plan year 2015; potentially resulting in duplicate coverage and federal payments. As open enrollment for plan year 2016 has just begun, what, if anything, is CMS doing this year to check for Medicaid coverage before automatically enroll people?

5) CMS recently announced plans to begin conducting periodic data matching to identify consumers who were dually enrolled in Medicaid and subsidized exchange coverage.[7]
   a. Please describe the results of the first round of data matching, including the number of individuals with duplicate coverage and the amount of duplicate federal payments resulting from this coverage.
   b. What is being done to recover duplicate federal payments that resulted from dual enrollment?
   c. Will the results from this data matching be published?
   d. How frequently will CMS conduct this data matching?

6) CMS's periodic data matching is intended to identify duplicate coverage and federal funding after the fact. What is being done to proactively prevent this duplication from occurring?

7) As noted earlier, GAO did not find any changes or improvements in CMS's control system for healthcare.gov between 2014 and 2015. What actions has CMS taken in response to GAO's findings and how has CMS improved its control system for the current open enrollment period?

8) Given GAO's ability to enroll 28 of 30 applicants using counterfeit documentation over the past two years, what steps is CMS taking to ensure the authenticity of documents provided to support an individual's eligibility for federally subsidized coverage?

9) What is CMS doing to assess whether applicants seeking subsidized exchange coverage have access to minimum essential coverage through their employer?

[7] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Periodic-Data-Matching-FAQ-92815.pdf

10) It is our understanding that CMS has a contract to verify income using Equifax's *The Work Number*® if all nine specified data fields are matched and the information has been updated in the last 90 days. It is our understanding that additional potentially useful information would be available to CMS to verify income if the agency adjusted its data requirements. Please explain CMS's reasoning for not accepting additional payroll data as a means of verifying individuals' eligibility for subsidized coverage.

Thank you for your attention to this important matter. We respectfully request your response to this letter no later than 45 days upon receipt of this letter. If you have any questions, please contact Josh Trent or Michelle Rosenberg with the Committee at (202) 225-2927.

Sincerely,

Fred Upton
Chairman
Committee on Energy and Commerce

Joseph R. Pitts
Chairman
Subcommittee on Health